Nova Scotia Health

CardioVascular HEALTH NOVA SCOTIA

BULLETIN

IMPROVING CARDIOVASCULAR HEALTH OF NOVA SCOTIANS

Volume 6 **Issue 3** **Winter 2012**

Welcome to the Cardiovascular Health Nova Scotia (CVHNS) e-mail bulletin, produced 3 times annually. The Bulletin has been created to share information about the program's activities, related cardiovascular health initiatives, and ideas from around the province.

The C-Change Initiative

The number of clinical practice guidelines has multiplied in the past decade. Practicing physicians are confronted with an overabundance of guidelines; websites such as the Canadian Medical Association's Infobase and the National Guideline Clearinghouse contain thousands of practice guidelines, many of which are available for the management of cardiovascular illnesses. A group of guideline developers in Canada wanted to make life simpler for primary care physicians who were dealing with patients with multiple co-morbidities; their goals were to establish a common vision and action plan for the prevention and treatment of chronic atherosclerotic disease in Canada and produce a harmonized set of guidelines. Out of this vision, the C-Change (**C**anadian **C**ardiovascular **Ha**rmonization of **N**ational **G**uidelines **E**ndeavour) initiative evolved. Representatives from Canadian Association of Cardiac Rehabilitation; Canadian Cardiovascular Society; Canadian Cardiovascular Society Lipid Guidelines Group; Canadian Action Network for the Advancement, Dissemination and Adoption of Practice Informed Tobacco Treatment; Canadian Diabetes Association; Canadian Hypertension Education Society; Canadian Society for Exercise Physiology; Obesity Canada and Canadian Stroke Network agreed to participate in this initiative.

The C-CHANGE Initiative used a consensus model to harmonize and integrate more than 400 recommendations from eight separate guidelines into 89 key recommendations for the management of cardiovascular risk factors. The process took over 12 months to complete. The harmonized guidelines provide recommendations on screening and risk stratification, diagnostic strategies and treatment, including changes to health behaviours and pharmaceutical treatments for all the major cardiovascular risk factors that can lead to complications such as stroke, heart attack and sudden cardiac death.

The authors of the guidelines have highlighted the following key points:

- "Multiple practice guidelines for similar conditions create challenges because of redundancy, discordance, different priorities for treatment and different evidence bases.
- The risk of future cardiovascular events should be determined using established scoring systems in all patient's older than 40 years.

- Treatment targets must be based on the individual patient's level of risk.
- Recommended healthy behaviours for all patients include no smoking, following a diet capable of promoting energy balance and a healthy body weight, and adequate weekly physical activity.
- A combination of modifications to health behaviours and pharmacologic interventions will be required in most patients at high and moderate risk of cardiovascular events to meet treatment targets."[1]

Phase one of this initiative focused on harmonization of existing guidelines. Phase two will focus on working with the core guideline groups to update the harmonized guidelines on a regular basis and focus on improving the clarity of the recommendations. The C-Change group will also focus efforts on implementation of the guidelines and have elicited the assistance of guideline implementation experts and electronic medical records specialists. They plan to develop multiple education and information platforms such as peer led interactive educational sessions, web-based case studies, smart phone applications, peer tutoring materials and point of care decision support systems.

Future challenges and opportunities are also identified in the document. The process of developing the guidelines has raised many questions. The guideline team plans to address these research questions and will continue to work on improving the harmonized guidelines to assist health care workers in delivering effective guideline based care.

[1]Tobe SW, Stone JA, Brouwers M. Harmonization of guidelines for the prevention and treatment of cardiovascular disease: The C-CHANGE Initiative. CMAJ.2011;183(15): E1135-1150.

Learning Opportunities

17th Annual Atlantic Canadian Cardiovascular Conference
April 19-22, 2012. Halifax, NS. 902-494-7433 or mary.ann.robinson@dal.ca; http://cme.medicine.dal.ca/17_accc.html.

Best Practice in Stroke Care
April 19-20, 2012, Charlottetown, PEI
Phone: 902-892-7441; healthpromotion@hsfpei.ca

2012 Annual Canadian Association for Health Services and Policy Research Conference
May 29-31, 2012, Montreal, PQ. www.cahspr.ca.

National Health Leadership Conference (NHLC)
June 4-5, 2012, Halifax, NS. www.nhlc-cnls.ca.

15th Annual Cape Breton Cardiology Day
June 8, 2012, Sydney, NS. 902-567-8007.

7th Annual Atlantic Canada Stroke Conference
September 14-15, 2012, Halifax, NS.
http://cme.medicine.dal.ca/cme_calendar.htm.

New Brunswick Heart Centre's 22nd Annual Cardiovascular Symposium
September 20-22, 2012, Saint John, NB.
www.ahsc.health.nb.ca/Programs/NBHC.

3rd Canadian Stroke Congress
Sept 29—Oct 2, 2012, Calgary, AB.
www.strokecongress.ca.

CVHNS News

2010 Cardiac Quality Indicator Reports

The 2010 quality indicator reports will soon be mailed out to the CEOs for distribution in each district health authority. The reports provide an overview of care provided in the DHA compared to the province between 2008 and 2010 for patients with an admitting diagnosis of AMI, a discharge diagnosis of ST elevation myocardial infarction, a discharge diagnosis of Non-ST elevation myocardial infarction or a discharge diagnosis of congestive heart failure. These reports provide information on demographics, times to hospital presentation and treatment, acute and discharge drug regimens, cardiac procedures and outcomes. DHA comparison tables will also be provided for key quality indicators. These reports should inform districts of areas for quality improvement. CVHNS can be booked to present the data to districts and we are also able to provide more frequent analyses and reports for specific sites or indicators upon request. For more information, contact kathy.harrigan@cdha.nshealth.ca or your local cardiac district coordinator.

Successful Stroke Forum Sparks Change

In November 2011, CVHNS hosted a stroke forum called "Improving Timely Access to Stroke Care in the Emergency Department" to focus on the development of quality improvement plans to improve door to CT and door to needle times for those patients who arrive within 3.5 hours of symptom onset and may be eligible for tPA. Data were provided that showed all districts are struggling to meet the nationally recognized door to CT benchmark (25 minutes) and door to needle benchmark (60 minutes). Participants worked within their district stroke programs to develop a quality improvement plan to implement when they got home. Many districts have focused their efforts on a "Code Stroke" protocol, whereas others are looking at more specific components of care such as lab, or diagnostic imaging.

A follow up teleconference was held in February 2012. The following changes were reported:

- development of a "tPA box",
- development of a formal "Code Stroke" protocol,
- identification of stroke patients on lab orders,
- and changes to process when diagnostic imaging staff are called in after hours.

Not all districts have had a chance to test their improvement idea yet, but all were impressed with the engagement and dedication they found at the district level to make this change happen. A second follow up call will be scheduled for mid-late April to get further feedback on how these changes are impacting door to CT and door to needle times in the province. For more information, contact katie.white@cdha.nshealth.ca or your local district stroke coordinator.

My Blood Pressure Card Initiative

CVHNS, DCPNS, and NSRP are following up with key contacts in each DHA for distribution of the My Blood Pressure Card materials. We are interested in learning more about how materials have been used in the DHAs and success stories that can be shared to help stimulate increased use of the materials in a variety of settings and innovative manners. Once the interviews are completed, the results will shared in a variety of ways.

We have also released the My Blood Pressure materials in French; the materials have been sent to French Language Coordinators in each DHA. Materials for First Nations and immigrant populations are underway and will be released shortly.

World Hypertension Day is May 17, 2012. The theme this year is **Healthy Lifestyle-Healthy Blood Pressure**. Cardiovascular Health Nova Scotia, Diabetes Care Program of Nova Scotia and the Nova Scotia Renal Program will be planning activities during the month of May including **The Come on Nova Scotia...Check it! Challenge**. This province-wide challenge aims to increase awareness of the importance of knowing your blood pressure and encourages all Nova Scotians to have their blood pressure checked, learn more about blood pressure and use our provincial My Blood Pressure Tools. If you are interested in hosting a challenge, order a challenge package from info@nsrp.nshealth.ca.

Check the website www.gov.ns.ca/bloodpressure regularly for new materials/information.

DHA News

PCHA Emergency Department Responds to CVHNS Data

Each year, CVHNS provides our district with a quality indicator report for patients discharged with a diagnosis of acute myocardial infarction (AMI). The latest data (2009) indicated that our door to ECG and door to needle times had increased significantly from the last report. PCHA established a working group to address the areas of concern; the team consisted of the emergency department (ED) unit manager, the CVHNS district coordinator, ED front line nurses and support from the Director of Nursing.

The working group decided to focus on how to share the data, and how to obtain input from frontline staff delivering care. The working group held informal focus groups in the ED break room so staff did not have to leave their environment and could drop in as their workload permitted. Staff was able to identify key barriers to meeting timelines, and offered up potential solutions to the barriers. This led to implementation of a few key changes, as suggested by front line nursing staff.

- An AMI Bulletin Board was set up in the ED break room to post data as well as summary documents from the focus groups.
- A dedicated area for ECG performance was established.
- An "ECG stat" policy was introduced, piloted and amended. This ensured the first available staff performed the ECG on incoming chest pain arrivals.
- The ECG machine was modified to allow immediate tracing, without the need for extensive data entry while the patient was experiencing their myocardial infarction.
- Clock synchronization activities were initiated, so computers, monitors, and wall clocks all displayed the same time.

PCHA is continuing to focus on improvements in this area. ED nurses and a paramedic offered a presentation to inform the public of the importance of seeking timely care when having an AMI. We have also applied for and received a quality improvement grant from CVHNS, enrolled in Safer Health Care Now's virtual collaborative and continued to audit charts and provide feedback to

ED staff on timelines. It is hoped that future CVHNS reports will reflect the commitment that frontline staff have invested in this area of ED care. For more information please contact Kathy Saulnier at katherine.saulnier@pcha.nshealth.ca.

Helpful Resources

Canadian Cardiovascular Society Data Dictionary
CCS recently released the first two chapters from their new data dictionary: Core elements and demographics data, and Acute Coronary Syndrome data elements and definitions. The Coronary Angiography/Revascularization data dictionary chapter is coming soon. Visit http://ddqi.ccs.ca/

Smoking Cessation Tools—A patient support website developed by the US Tobacco Control Research Branch of the National Cancer Institute
Visit www.SmokeFree.gov/

SaferHealthCare Now! Improved Care for AMI: Revised Getting Started Kit
Visit www.saferhealthcarenow.ca/EN/Interventions/ami/Pages/resources.aspx.

Dietary Portfolio for Hyperlipidemia
Jenkins DJA, Jones PJH, Lamarche B et al. Effect of a dietary portfolio of cholesterol-lowering foods given at 2 levels of intensity of dietary advice on serum lipids in hyperlypidemia: A randomized controlled trial. JAMA. 2011;306(8):831-839.

CADTH Reports on Optimal Warfarin Management for Prevention of Thromboembolic Events in Patients with Atrial Fibrillation
Available from www.cadth.ca/en/products/optimal-use/warfarin-management/reports.

Canadian Cardiovascular Society Guideline Tools
Several new tools are available including videos on dyslipidemia guidelines and new pocket guidelines for atrial fibrillation and congestive heart failure. Available from www.ccsguidelineprograms.ca.

Diagnosed Hypertension in Canada
Robitaille C, Dai S, Waters C, et al. Diagnosed hypertension in Canada: Incidence prevalence and associated mortality. *CMAJ*. 2012;184(1):e49-E56.

Campbell N, Young ER, Drouin D, et al. A framework for discussion on how to improve prevention, management, and control of hypertension in Canada. Canadian *Journal of Cardiology*. 2012:Jan 25 published ahead of print.

Canadian Hypertension Education Program
The new 2012 slide decks are available online. Visit www.hypertension.ca.

Innovative Ideas

CDHA Launches *My Health Passport*
CDHA and the IWK have partnered with the Sick Kids Hospital in Toronto on this project to offer online access to this tool. A health passport is a wallet sized card that lists medical conditions, allergies, medication, past procedures, treatments and other health conditions. The passport can be built on line by a health professional, family member or patient. No information is stored on the My Health Passport website, but, it is possible to print or email an electronic version of the passport once built on line. Visit http://www.cdha.nshealth.ca/patients-clients-visitors/myhealth-passport.

South West Health Develops Mandatory e-learning Tutorial on Smoking Cessation for Nursing Staff
Over the past year much work has been done to improve the care, resources and supports needed for

patients who are admitted to our hospitals and currently smoke or who may have recently quit and are trying to remain smoke-free. To assist nurses in supporting smokers during their hospitalization, an e-Learning tutorial is in development which has been deemed mandatory learning for all nursing staff every two years. The tutorial covers current statistics, benefits of quitting, stages of change, sample forms including new order sets for nicotine replacement therapy, and the Ask, Advise, Assist approach. The beginning of the tutorial includes a brief quiz to test the learners' current knowledge around smoking cessation with a final quiz at completion to reiterate the material covered within the tutorial. The tutorial content has been researched and developed with the help of a 4th year Dalhousie University (Yarmouth site) nursing student. A document technician (Library Services) will add creative touches to the slides and ensure readability, flow and ease of use. The e-Learning tutorial and other smoking cessation tools of the initiative will be rolled out over the next few months within SWH. For more information, contact Kelly Goudey kgoudey@swndha.nshealth.ca.

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Changes to Product Monography for Pradax (Dabigatran)

On March 16, 2012, Boehringer Ingelheim distributed communication about changes to the Product Monograph for Pradax (Dabigatran) as a result of post-marketing reports of serious bleeding in certain populations. The new recommendations for Pradax include:

- Given that renal impairment is a risk factor for bleeding with Pradax:
  - Prior to initiation of treatment, renal function should be assessed in all patients to exclude patients with severe renal impairment.
  - While on treatment, renal function should be assessed routinely in clinical situations when a decline in renal function may be suspected.
  - In elderly patients (older than 75 years) or in patients with moderate rental impairment, renal function should be assessed at least once a year.
- Use of pradax in patients with hemodynamically significant rheumatic valvular heart disease, especially mitral stenosis, or in patients with prosthetic heart valves is not recommended.

Visit http:/www.boehringer-ingelheim.ca/en/human_health/our_products.html.